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June 10, 2005

HAND DELIVERED

Commissioner Robert E. Nicolay
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore MD 21215

Re: Certificate of Need Task Force

Dear Commissioner Nicolay:

I am writing this letter based on your advice that members of the Certificate of Need Task Force should send you a letter adding their concerns to those received either at the June 7, 2005 public hearing or via written submission.

In that regard, as an observer and a participant in the CON process, I believe there is some frustration by some of the "customers" of the Commission in regard to both their day-to-day dealings with the Commission, and their ability to predict some Commission outcomes. Moreover, it is possible that this frustration may be rooted in the natural tendency for government to create and apply rules, without always reflecting on the reasons that underlie those rules. Therefore, perhaps, one by-product of this Task Force may be to encourage the Commission to focus somewhat more on the forest and somewhat less on the trees.

I. *Laissez-Faire* Tension

The first step in this focusing effort is I believe a recognition of the difficult job that the Maryland Health Care Commission has been asked to perform in regard to Certificates of Need. Most of us believe in a *laissez-faire* attitude on behalf of the government when it comes to business. More specifically, most Americans are "wired" to believe that competition is good, that more competition is better, and that competition leads to innovation and lower costs. Therefore, there is always a tendency for the Commission to drift toward becoming an economic development agency by encouraging new services, even though the Commission's actual statutory mandate is to resist that temptation.

Notwithstanding this pro-competition predilection we all share, the Maryland General Assembly has unquestionably asked the Maryland Health Care Commission to "restrict" competition in the health care arena. Therefore, while the anti-competitive nature of Certificate of Need legislation should be acknowledged, so should the General Assembly's conclusion that the free market should not always be in control of the delivery of health care, because there are public health goals that are better served through regulation.

II. The "Whys"

After acknowledging that the Certificate of Need process is intended to be anti-competitive, I believe the next step in focusing on the forest should be a recognition by the Commission that it should, nevertheless, "only" interfere with free competition when there is a "reason" to do so. In other words, I believe it is important for the Commission to articulate "why" there is a Certificate of Need process, and "why" it is appropriate to interfere with free competition in certain situations. If the Commission articulates those reasons, then I believe the Commission will be able to tailor its decisions, its regulations and its processes in a way that keeps those reasons in mind.

Although the following list is not necessarily exhaustive, I believe that there are at least three reasons why free competition in health care should be stifled, namely to keep costs down, to improve patient safety or to protect the mission of particular institutions, and I believe that there is one overriding concern that should "trump" these CON rationales, namely need.

A. Costs. With respect to costs, if it can be shown that the expansion of a service will cause the cost of that service to go up, then there might be a reason to restrict such expansion. The problem, however, is the disconnect between cost and price. For example, the notion that overcapacity causes an increase in prices may be dated for some health care providers, given the way today's prices of health care are determined. At a time when providers were freely permitted to charge and receive payments on a cost plus basis, this concept of expansion leading to higher prices made much more sense. Today, many services are paid on a prospective payment basis, and not on a cost plus basis. Moreover, today there are significant purchasers of services, such as Medicare, which are able to dictate the prices they will pay, regardless of cost.

Even Maryland's Health Services "Cost" Review Commission has arguably become Maryland's Health Services "Revenue" Review Commission. While there are still certain special circumstances when costs drive hospital rates in Maryland, which circumstances are discussed in more detail in Section III of this letter, the primary driver of hospital rates in Maryland today is no longer "cost," but nationwide hospital "revenues." For the last three years, Maryland hospitals have been able to charge rates that result in their aggregate operating revenues being two percent (2%) less than the nation's hospitals' revenues per adjusted in-patient admission.

The bottom line is that requiring a CON may in some situations keep costs and prices down, but that should not be presumed. If expansion of a service will increase costs and prices, then requiring a CON is appropriate. However, if that is not the case, then there should be no requirement for a Certificate of Need, unless one of the other CON rationales is triggered.

B. Safety. There are situations where there is evidence that patient safety is enhanced by limiting the number of providers. For example, sometimes quality and volume are related. Another example might be an industry with a low capital investment threshold where perhaps limiting the number of providers allows better governmental oversight, and thereby enhances patient safety. Interfering with free competition is sensible in such situations. If that is not the case, however, then the interference is not warranted, unless one of the other CON rationales is triggered.

C. Mission. There are institutions that are particularly situated by location and/or mission to serve otherwise underserved populations. If permitting the expansion of a service would jeopardize an institution's ability to continue to meet such a mission, then a Certificate of Need would be warranted. Otherwise, it would not, unless one of the other CON rationales is triggered.

D. Need. Underlying the entire process is, of course, "need." While free competition should be stymied because of cost, safety or mission, such restriction should be lifted when a party establishes a "need" to do so.

Accordingly, how the Commission determines "need" is of great importance. Population growth and movement, driving times, waiting times, statistically significant underutilization of services, and statistically significant higher than expected rates of death or untreated disease, are ways of articulating need. However, basing need on hard to understand and arguably arbitrary "rules" only undermines the Commission's credibility. For example, why allow the expansion of a service if the only way to justify it is to ignore the fact that patients' needs are being met by their traveling a few miles into another jurisdiction? Similarly, why allow an expansion if the only way to justify the expansion is because years ago a need was mistakenly identified? In other words, the fact that a need has never materialized is evidence that there is no need, not evidence that another provider should be given another chance to fail.

Of course, another way to say all of the foregoing is that the Certificate of Need process should be clearly tied to cost, quality and/or access.

III. Application of the CON Rationales

Application of the foregoing principles to a few particular situations may be instructive.

1. Capital Expenditures. Presently, hospitals, as well as other health care facilities, must seek a Certificate of Need, or request an exemption from obtaining a Certificate of Need, before they make capital improvements to their health care facilities in excess of $1.6 Million for things other than office equipment or major medical equipment or certain projects not related to patient care. Why? Whether a Baltimore City hospital with $300 Million in annual revenue spends $2 Million or not, will not impact the cost of obtaining services at that hospital. It will also not impede the safety of patients. It will also not threaten other hospitals in Baltimore City meeting their missions. Then, why have the matter come to the Maryland Health Care Commission at all?

The HSCRC's recent foray into partial rate reviews has only exacerbated the capital threshold situation. In the late 1990s and early in this Century, the HSCRC's annual rate increases were very modest, because in the mid-1990s, the HSCRC had been much too generous. Nevertheless, the string of modest increases made it difficult for Maryland's hospitals to continue to meet their ongoing capital needs. Accordingly, the HSCRC created a safety valve allowing hospitals to petition for rate increases to fund their capital needs, provided that those hospitals first went to the Maryland Health Care Commission so that the Maryland Health Care Commission could certify that there was a "need" for such capital projects. Now that the HSCRC has increased rates liberally over the last three years, there is no longer any reason for the HSCRC to continue the partial rate review process. The HSCRC should be giving hospitals enough money via the HSCRC's annual Update to support their capital needs, and there should neither be a requirement nor a need to seek any approval from the Maryland Health Care Commission for capital projects below a very sizeable threshold.

Moreover, while a hospital may avoid the CON requirement for a capital expenditure if the hospital pledges not to seek an increase in rates, the process for obtaining a CON waiver has itself become burdensome, being referred to in the industry as a "mini-CON."

The bottom line is that the $1.6 Million threshold is patently too low. Even if a hospital were to launch a capital program that was equal to 10% of its annual revenue, the additional cost that program would place on that hospital would be about one percent (1%) of its annual revenue, assuming interest and amortization costs equal to 10% of the capital expenditure. Why should the Maryland Health Care Commission be asked to second-guess that hospital's board, that hospital's bank, or that hospital's architect for expenditures that put less than a 1% burden on the hospital?

While others are advocating for an increase in the capital expenditure threshold to 7.5 or 10 Million Dollars, perhaps a more flexible approach should be considered, namely a threshold that is equal to a percentage of a facility's annual revenue. Ten Million Dollars is a lot of money for some facilities, but not a lot of money for others.

2. Establishment of a Hospital. On the other hand, while capital projects below a sizeable threshold should not require a CON, the establishment of a new hospital arguably presents a different situation than the renovation of an existing hospital. It is possible to argue that the establishment of a new hospital may draw so many patients away from an existing hospital to render that existing hospital so inefficient that it will not be able to meet its mission, and, therefore, instead of the new hospital increasing access to services, the establishment of the new hospital might actually result in a lessening of access to services. Therefore, it would be appropriate for the Maryland Health Care Commission to weigh in before such a new service were established.

3. Changes in Bed Capacity. The CON requirements for changes in bed capacity need to be reevaluated to recognize that Maryland now licenses beds based on a percentage of occupancy. In many cases, a hospital's board may determine that increasing potential bed capacity is desirable – whether to cover periods of peak admission, national emergencies, or because the cost of adding "shell space" at a particular time is cheaper than adding it at a later time. Increases in bed capacity do not automatically enable a hospital to start filling those beds. Neither should an increase in bed capacity entitle a facility to an increase in patient charges.

The Maryland Health Care Commission should not use the CON process to second-guess the business judgment of a health care facility as to the pros and cons of increasing or decreasing bed capacity, where doing so does not have a material negative impact on price, safety or the mission of affected competitors. More specifically, while a CON to increase bed capacity might make sense in a jurisdiction with two hospitals, perhaps it does not make sense in a jurisdiction with one hospital or with multiple hospitals.

IV. Culture of Rules

It is possible that over the last several years, the Maryland Health Care Commission may have inadvertently focused too heavily on its own rules, whether or not those rules are consistent with the underlying reasons for requiring Certificates of Need. Applications have become more tedious and more costly for applicants. Some completeness questions appear to be asked because the questioners are curious, not because the answers bear a direct relationship to the underlying reasons for Certificates of Need. Applications and follow-up questions should be streamlined. Applicants should be asked to comment on cost, quality, access and need, and nothing else.

For example, perhaps it would be instructive to ask Commissioner Ginsburg, a member of this Task Force, to comment on how much of the information that he was provided, either in writing, or during the many days of hearings, during the recent open heart comparative review, that he found useful to his ultimate recommendation. If only 10% of the information was useful, then perhaps only 10% of the information should be sought or permitted.

Similarly, you recently mentioned that a 100-page Opinion was being finalized with respect to a particular Certificate of Need application. How much of that decision goes to the reasons why there is a Certificate of Need process, versus how many pages of that decision address regulations that may only be tangentially related to such reasons? In all likelihood, "less may be more."

IV. Statutory Revisions

Admittedly, many of the regulations and processes being followed by the Maryland Health Care Commission exist because the Commission's underlying statute requires that those processes exist. Accordingly, any streamlining of the CON process will not only require serious introspection at the Commission, but also legislative action.

In particular, I believe that the underlying statute is written upside down. It starts with the premise that one should obtain a Certificate of Need for "every" health care service, and then the statute goes on to carve things out of this over-inclusive net. On the contrary, I believe that the statute should state that there is no need for a Certificate of Need, unless there are cost, quality or access reasons to require a CON.

V. Deliverables

I believe that the Commission should:

1. Clearly articulate the principles that should form the basis of the CON process;

2. Direct Staff to rewrite the State Health Plan in a manner that is consistent with such principles, and submit the same to the Commission for its approval and/or modification;

3. Direct Staff to review the Commission's regulations and processes to determine if such regulations and processes are consistent with the adopted principles, and to recommend to the Commission necessary changes to such regulations and processes;

4. Make recommendations to DHMH and the HSCRC for changes that these sister organizations should consider making to their regulations or processes that would enhance the Commission's ability to implement the Commission's adopted principles; and

5. Direct Staff to review the Commission's statutory authority in light of the adopted principles for the purpose of allowing the Commission to recommend changes to such statutory authority for the consideration of the Maryland General Assembly, as appropriate.

In summary, I believe that the potential for the Task Force to serve the health care industry and the people of Maryland is significant, and I thank you very much for giving me this opportunity to share my comments with the Task Force. I am looking forward to hearing the opinions of others, and to joining my fellow Task Force members in offering constructive recommendations to the Commission.

Yours truly,

Barry F. Rosen

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cc: Pamela Barclay